The Protection of Conscientious Objection against Euthanasia in Health Care

A Knoetze* and S de Freitas**

Online ISSN
1727-3781

P·E·R

Pioneer in peer-reviewed, open access online law publications

Authors

Adriaan Knoetze
Shaun de Freitas

Affiliation

FEDSAS South Africa
University of the Free State
South Africa

Email

lo2@fedsas.org.za
defreitas@ufs.ac.za

Date Submission

17 September 2018

Date Revised

28 July 2019

Date Accepted

28 July 2019

Date published

20 September 2019

Editor Prof Avitus Agbor

How to cite this article
Knoetze A and De Freitas S "The Protection of Conscientious Objection against Euthanasia in Health Care" *PER / PELJ* 2019(22) - DOI http://dx.doi.org/10.17159/1727-3781/2019/v22i0a5590

DOI
http://dx.doi.org/10.17159/1727-3781/2019/v22i0a5590

Abstract

In 2015 the South African judiciary was confronted with the issue of the so-called "right to die", when Robin Stransham-Ford applied to the High Court of South Africa (the North Gauteng Division) for an order to have his life terminated. Although the Supreme Court of Appeal set aside the order (on procedural grounds), the High Court's judgment paved the way towards renewed attention regarding the possible legalisation of euthanasia. A pertinent question arising from this is whether a medical practitioner may be compelled to participate in the administering of euthanasia. Bearing this in mind, this article argues for the protection of the rights of medical practitioners who conscientiously object to participating in the administering of euthanasia, especially where such an objection is based on religious beliefs. From this arises the necessity to investigate the rights applicable both to the medical practitioner and the patient (which focusses on the right to freedom of religion and personal autonomy), the weighing up against one another of the different meanings ascribed to such rights, as well as the postulation of a substantively competitive rationale against the background of the importance and sacredness of human life. This also overlaps with the importance of the endeavour towards higher levels of religious freedoms and consequently of plurality in democratic societies. Applying the proportionality test in the analysis whether a medical practitioner's rights may be reasonably and justifiably limited against the background of administering euthanasia also strengthens the argument for the protection of the medical practitioner's right to object conscientiously to the administering of euthanasia. This, together with the vacuum there is in substantive human rights jurisprudence related to this topic, suggests the importance of this article both for the South African context and beyond.

Keywords

Right to freedom of religion; religious rights; religious freedom; conscientious objection; euthanasia; medical ethics; the right to life; human dignity and religion; the right to privacy and religion; personal autonomy and religion.

.....

1 Introduction

In 1998 the government instructed the South African Law Commission to draft a report called the *Law Commission Report on Euthanasia and the Artificial Preservation of Life*, Project 86. This report entailed a comprehensive investigation of euthanasia and assisted suicide, and it was addressed to the Minister of Justice, as determined by the *South African Law Commission Act*,[1] for possible approval.[2] However, no further legal development took place until more than a decade later, on 30 April 2015, when the South African High Court (as per Fabricius J)[3] consented to Robin Stransham-Ford's application to the court, allowing a medical practitioner to euthanise him. Although Stransham-Ford passed away before the order of the judge could be complied with, moral and jurisprudential concerns regarding euthanasia were now the topic of discussion. Fabricius J had held that the said ruling served as a basis for the further development of the law regarding euthanasia:

> The topic is in my view important enough, having regard to the relevant principles contained in the Bill of Rights, that serious consideration be given to introducing a Bill based on the South African Law Commission's Report, which suggested a number of options, but supported the development of the common law in this context. It is certainly a topic that deserves broad discussion, but in the context of the Bill of Rights especially.[4]

---

* Adriaan Knoetze. LLB LLM (UFS) is an admitted attorney employed at the Federation of South African School Governing Bodies (FEDSAS) in South Africa, where he is involved in writing legal opinions, commenting on policy and departmental documents and providing legal advice to schools. E-mail: lo2@fedsas.org.za. This article stems from my unpublished Masters in Law dissertation titled *The Right to Conscientious Objection against Administering Euthanasia in the Context of the Right to Freedom of Religion* (UFS 2018).

** Shaun de Freitas. B Proc LLB LLM LLD (UFS). Professor, Faculty of Law, University of the Free State, South Africa. Adjunct Professor, School of Law, University of Notre Dame Sydney (Fremantle Campus). E-mail: defreitas@ufs.ac.za.

1 *South African Law Commission Act* 19 of 1973 (now the *South African Law Reform Commission Act* 19 of 1973, as amended by the *Judicial Matters Amendment Act* 55 of 2002), s 7(1).

2 *Stransham-Ford v Minister of Justice and Correctional Services* 2015 4 SA 50 (GP) para 1.

3 *Stransham-Ford v Minister of Justice and Correctional Services* 2015 4 SA 50 (GP).

4 *Stransham-Ford v Minister of Justice and Correctional Services* 2015 4 SA 50 (GP) para 1. Despite its irrelevance to the argument in this article, it may be of interest to note that the case proceeded to the Supreme Court of Appeal (SCA) in *Minister of Justice and Correctional Services v Estate Late James Stransham-Ford* 2017 3 SA 152 (SCA). The SCA was of the view that the Pretoria High Court erred (on procedural grounds) in making the decision it did, and upheld the appeal by the Minister of Justice and Constitutional Development (para 101).

Although there is extensive legal scholarship on euthanasia,[5] there is an evident void in scholarship regarding the protection of the freedom of medical practitioners[6] to object conscientiously to administering euthanasia.[7] This article argues for the protection of conscientious objection by medical practitioners regarding the administering of euthanasia in South Africa, and that this is of relevance to other democratic and plural societies that may be confronted with conscientious objection claims related to euthanasia within the health care system. The article begins with an explanation of the various types of euthanasia applicable, and goes on to elaborate on the importance of the right to freedom of religion and its inextricable relationship with other substantive rights such as the right to life, human dignity and privacy. It is further postulated that an unreasonable and unjustifiable infringement on the medical practitioner's basic rights indeed occurs where the law compels a medical practitioner to participate in the administering of euthanasia.

2 Clarifying the categories of euthanasia

Euthanasia is a broad concept fraught with a multitude of views, and frequently confusion exists in this regard.[8] According to John Keown, if different parties understand euthanasia to mean quite different things, their discussion is likely to be fruitless and frustrating.[9] It is therefore important to provide views on what constitutes euthanasia for the purposes of the

5 Regarding the South African context, see for example: Egan 2008 *SAJBL* 47-52; McQuoid-Mason 2015 *SAJBL* 34-40; Slabbert and Van der Westhuizen 2007 *SAPL* 366-384; Malherbe and Venter 2011 *TSAR* 466-495. For views beyond the South African context see, for example, Keown *Euthanasia, Ethics and Public Policy*; Russel *Freedom to Die*; Novak *Sanctity of Human Life*; Paterson *Assisted Suicide and Euthanasia*; Finnis 1998 *Loy LA L Rev* 1125.

6 For clarity on who should be included in the category of "medical practitioner", Theriot and Connellys' referral to the description given by the *Mississippi Code* Annexure § 41-107-3 (2016) should be followed. It refers to "health care provider" broadly as "any individual who may be asked to participate in any way in a health care service, including, but not limited to: a physician, physician's assistant, nurse, nurses' aide, medical assistant, hospital employee, clinic employee, nursing home employee, pharmacist, pharmacy employee, researcher, medical or nursing school faculty, student or employee, counsellor, social worker or any professional, paraprofessional, or any other person who furnishes, or assists in the furnishing of, a health care procedure". Theriot and Connelly 2017 *Ariz St LJ* 581-582.

7 For example, the following substantive sources dealing with the right to freedom of religion and conscientious objection do not delve into the matter related to this study: Ahdar and Leigh *Religious Freedom*; and Wicclair *Conscientious Objection in Health Care*.

8 Chao, Chan and Chan 2002 *Family Practice* 128.

9 Keown *Euthanasia, Ethics and Public Policy* 9-10.

protection of the medical practitioner's freedom to object conscientiously to the administering of euthanasia. "Active" euthanasia normally involves the health practitioner's taking deliberate steps to end the life of a person who voluntarily requests such steps due to suffering. More specifically, Keown is of the view that voluntary active euthanasia is generally understood as euthanasia at the request of the patient,[10] which implies that involuntary active euthanasia takes place without the patient's having requested it.[11] Then there is the doctrine of the double effect, which covers the administration of drugs to relieve a terminally ill patient's pain and suffering, despite the medical practitioner's awareness that this may have the incidental effect of hastening the patient's death.[12] This could be understood as being inextricably related to active euthanasia, and may overlap with forms of both "voluntary" and "involuntary" active euthanasia. Passive euthanasia, on the other hand, does not comprise the taking of actual deliberate steps to end the life of the person through some procedure, but the omission to prolong life.[13] This involves the cessation of the treatment of a patient, such treatment being the sole cause of continuing the patient's life. This specifically entails that the patient be removed from any life support equipment, where had it not been for such equipment, the patient would have succumbed already.[14] One can argue that passive forms of euthanasia may also be voluntary or non-voluntary, and an example is where a medical practitioner, in following the stipulations of a patient's living will (which is discussed below), brings about the cessation of the provision of natural food or hydration to the said patient (who is unconscious). This may then be viewed as voluntary, whilst involuntary passive euthanasia is applied where the same omission is performed by the medical practitioner, but where there was no living will that confirms the patient's intention to have his/her life terminated in such a situation.

Besides the categorisation of euthanasia along the lines of active and passive euthanasia, there is also the administration of PAS (physician-assisted suicide). Stuart Beresford defines PAS as the involvement of the medical practitioner in providing a lethal substance to a patient to self-administer in order to commit suicide in a painless manner.[15] What sets it

10 Keown *Euthanasia, Ethics and Public Policy* 9.

11 Also see Beresford 2005 *Human Rights Research* 5; Paterson *Assisted Suicide and Euthanasia* 12.

12 Beresford 2005 *Human Rights Research* 5.

13 Garrard and Wilkinson 2005 *J Med Ethics* 64.

14 MacKinnon and Fiala *Ethics* 206. Also see Garrard and Wilkinson 2005 *J Med Ethics* 65.

15 Beresford 2005 *Human Rights Research* 5. Also see Paterson *Assisted Suicide and Euthanasia* 11.

apart from "ordinary active euthanasia" is that it is referred to as "suicide" in that, although the doctor assists the patient by providing the necessary paraphernalia,[16] the final step to end his/her life is ultimately taken by the patient him/herself.[17] Francis Beckwith and Norman Geisler explain that suicide where someone other than the person who chooses to die "assists such a person who chooses to die, to die", constitutes a form of active euthanasia. This makes sense against the background understanding that[18]

> … suicide is an individual's intentional ending of life, either by one's own hand, another's assistance, or by another's hand.

"Living wills" may also be related to euthanasia. For example, a person may stipulate in his/her will that if s/he is involved in a motor vehicle accident and left in an irreversible unconscious state, no prolonging medical should be administered. Instead, s/he should simply be allowed to pass away. According to Beckwith and Geisler, living wills may allow for either active or passive euthanasia.[19]

Bearing the above in mind, and for the purposes of this article, euthanasia should be understood as including both possibilities, active and passive. It has as its principal actor a medical practitioner or any other person clearly related to health care, whether directly involved (such as a physician who personally administers a deadly substance) or indirectly involved (such as a nurse who is approached to assist the former). It is also clear from the above that PAS may form part of euthanasia and that the "living will" is of relevance.

3 The right to freedom of religion and conscientious objection

The South African judiciary, especially the Constitutional Court, has adopted a positive approach regarding the importance and protection of the right to freedom of religion (and to thought, opinion, conscience and belief) against the background of the *Constitution of the Republic of South Africa*'s Bill of Rights.[20] This must consequently be the context of an argument in support

16 Such as drugs, toxins or machines.

17 Moss 2013 http://www.dignityindying.org.uk/blog/assisted-dying-not-assisted-suicide/.

18 Beckwith and Geisler *Matters of Life and Death* 155.

19 Beckwith and Geisler *Matters of Life and Death* 145.

20 *Constitution of the Republic of South Africa*, 1996 s 15(1): "Everyone has the right to freedom of conscience, religion, thought, belief and opinion." There have been a fair number of challenges presented before the South African Constitutional Court pertaining to the right to freedom of religion and emanating from these challenges

of conscientious objection against the intentional termination of innocent human life. Rex Ahdar and Ian Leigh comment that:[21]

> Medicine deals with pain, suffering, and death, subjects that touch the very heart of religion as well. It should not surprise anyone that medical treatment controversies often reflect differing world views of the protagonists … to insist there is a neutral, objective basis upon which to judge these conflicts is to maintain 'the fiction of neutrality'[22] as some medical ethicists call it. There is no 'View from Nowhere'.[23]

This is of relevance to conscientious objection against the administering of euthanasia by medical practitioners, as it deals with pain, suffering and death in a most fundamental manner and therefore naturally touches on the heart of many religions and their accompanying moral views. Robert George refers to the natural law argument for religious liberty, which is based on the obligation of each person to pursue the truth about religious matters.[24] In this regard, George comments:

> … religion – considered as conscientious truth seeking regarding the ultimate sources of meaning and value – is a crucial dimension of human well-being and fulfillment. It is among the basic human goods that provide rational motivation for our choosing. The right to religious liberty follows from the dignity of man as a conscientious seeker.[25]

George adds that religion pertains to ultimate matters; religion representing our efforts to bring ourselves into a "relationship of friendship with transcendent sources of meaning and value"; and that religion assists us to view our lives as a whole and forms an essential component of our flourishing as human beings.[26] According to Alan Brownstein:[27]

---

were constructive views by the judiciary regarding religion. In this regard, see *S v Lawrence* 1997 4 SA 1176 (CC) para 92; *Prince v President, Cape Law Society* 2002 2 SA 794 (CC) para 38; and *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC) para 19. Also see *Minister of Home Affairs v Fourie* 2006 1 SA 524 (CC) para 89. South Africa is also party to a number of international instruments regarding the protection of religious freedom, namely: *International Covenant on Civil and Political Rights* (1966) art 18; *African Charter on Human and Peoples' Rights* (1981) art 8; and *UN Declaration on the Elimination of all Forms of Intolerance and Discrimination based on Religion or Belief* (1981) arts 1.1, 1.2, 2.1, 2.2, 4.1, 4.2 and 7.

21 Ahdar and Leigh *Religious Freedom* 319.

22 Secundy and Sundstrom, cited in Ahdar and Leigh *Religious Freedom* 319.

23 Cowley, cited in Ahdar and Leigh *Religious Freedom* 319.

24 Second Vatican Council II *Declaration on Religious* s 2-3 800-801, cited in George, *Conscience and its Enemies* 91.

25 George *Conscience and its Enemies* 91.

26 George *Conscience and its Enemies* 118, 123. In this regard, George refers to Finnis *Natural Law and Natural Rights*.

27 Brownstein, cited in Ahdar and Leigh *Religious Freedom* 76.

> The free exercise of religion is essentially a dignitary right. It is part of that basic autonomy of identity and self-creation which we preserve from state manipulation, not because of its utility to social organization, but because of its importance to the human condition. Along with sexual autonomy, intimate association, and the dignitary aspects of speech, property and procedural due process, this is a right of self-determination and fulfillment, not social order and policy.

The State has the obligation to ensure that religious believers are not subjected to painful and agonising choices either to remain true to their religious convictions or to submit to the law,[28] as religious adherence is ingrained in the lives, cultures and temperaments of many believers.[29] In *S v Lawrence*, Chaskalson J quoted the following from *R v Big M Drug Mart Ltd*[30] by the Supreme Court of Canada:[31]

> The essence of the concept of freedom of religion is the right to entertain such religious beliefs as a person chooses, the right to declare religious beliefs openly and without fear of hindrance or reprisal, and the right to manifest religious belief by worship and practice or by teaching and dissemination.

Chaskalson J, also with reference to the said Canadian judgment, added that:[32]

> … freedom of religion implies an *absence of coercion or constraint* and that freedom of religion may be impaired by measures that force people to act or refrain from acting in a manner contrary to their religious beliefs.

Sachs J in *Christian Education* states that:[33]

> Religious belief has the capacity to awake concepts of self-worth and human dignity which form the cornerstone of human rights.

The South African Constitutional Court held in *MEC for Education: Kwazulu-Natal v Pillay* that it is:[34]

> … convinced that the [wearing of a nose ring for religious and cultural purposes] was a peculiar and particularly significant manifestation of her … identity. It was *her way of expressing her roots and her faith*. While others may have expressed the same faith, traditions and beliefs differently or not at all,

---

28 *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC) para 35.

29 *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC) para 33.

30 *R v Big M Drug Mart Ltd* 1985 1 SCR 295.

31 *S v Lawrence* 1997 4 SA 1176 (CC) para 92.

32 *S v Lawrence* 1997 4 SA 1176 (CC) para 92 (emphasis added).

33 *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC) para 36.

34 *MEC for Education: KwaZulu-Natal v Pillay* 2008 1 SA 474 (CC) para 90 (emphasis added).

> the evidence shows that it was important *for Sunali* to express her religion and culture through wearing the nose stud.

In this regard, the Court placed the focus on whether the religious practice was of importance to the believer himself/herself (and not primarily on whether the practice is in line with the tenets of a specific religion).

There is also the inextricable link between a religious belief and the conscience. "Conscience" refers to a person's inner knowledge, such as an internal conviction,[35] and can also refer to a practice based on what is right, which serves as a warning mechanism, exerting an effect on a person that a particular thought, action or feeling is wrong or evil.[36] Section 15 of the *Constitution of the Republic of South Africa* caters for the protection of a moral objection, or an objection based on one's conscience. In addition, having a religious belief and subsequently acting in accordance therewith is a core ingredient of any person's human dignity.[37] According to Mark Wicclair, many conceptions of the conscience incorporate the notion that matters of conscience involve,[38]

> … a particularly important subset of an agent's ethical or religious beliefs – *core* moral beliefs.

Wicclair adds that "conscience-based refusals" constitute the following:[39]

> (1) the agent has a core set of moral (i.e. ethical or religious) beliefs; (2) providing the good or service is incompatible with the agent's core moral beliefs; and (3) the agent's refusal is based on her core moral beliefs.

In this regard, and for the purposes of this article, it is emphasised that conscientious objection against the administering of euthanasia constitutes an inherent, serious and sincere aversion by a medical practitioner to participate in an act that impinges on deep religious (or secular) convictions regarding a matter that is inherently of serious concern, namely the intentional taking of innocent human life. The administering of euthanasia does not constitute an act of self-defence, but rather of intentionally terminating that which is believed to be (and this is a rational belief at that) an innocent human life that poses no substantive threat to those in the

35 Haigh and Bowal 2012 http://digitalcommons.osgoode.yorku.ca/clpe/316 23.
36 Haigh and Bowal 2012 http://digitalcommons.osgoode.yorku.ca/clpe/316 23.
37 *Christian Education South Africa v Minister of Education* 2000 4 SA 757 (CC*)* para 36.
38 Wicclair *Conscientious Objection in Health Care* 4.
39 Wicclair *Conscientious Objection in Health Care* 5.

presence of the patient.[40] The eminent legal philosopher Ronald Dworkin is of the view that abortion and euthanasia comprise two key areas of value conflict:

> Deep principled disagreement over the value of life plus respect for liberty of conscience empowers individuals to make their own choices. The meaning of the value of life is such a deeply contestable topic, open to many divergent viewpoints – viewpoints that can express sophisticated defences – that it is unreasonable for one viewpoint to seek to impose its account over all other viewpoints.[41]

It is precisely this disagreement regarding the value of life which confirms that the matter at hand is not clear-cut, and which in turn lends credibility to the convictions of the medical practitioner as well. This also explains, for example, the position taken by the judiciary in *Roe v Wade*,[42] the case that opened the floodgates of abortion in the US (and consequently around the world) about ensuring the protection of the medical practitioner's right to conscientiously object to participating in abortion practices.[43] It is precisely the differences of opinion about when human life precisely begins and about the legal and moral status of the unborn, that should allow for the protection of those who are substantively concerned about protecting what they believe to be human, such as the unborn (or the foetus).[44] The complexities and differences of opinion regarding the ending of human life in the context of the termination of innocent human life, even where it is the person himself/herself that wishes to die, for whatever reason are equally fraught.. In other words, the complexities and differences of opinion related to euthanasia should also allow for the views of those who respect and with to

40 It is important to note that there may be instances where a decision to withdraw further treatment that eventually leads to the death of the patient may be morally justified in the eyes of the medical practitioner who generally objects to partaking in practices in which euthanasia is exercised. In this regard, cognisance needs to be taken of the following view by Pope John Paul II: "Euthanasia must be distinguished from the decision to forego so-called 'aggressive medical treatment', in other words, medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family. In such situations, when death is clearly imminent and inevitable, one can in conscience 'refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted". Pope John Paul II 1995 http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html (hereafter *Evangelium Vitae*) para 65.

41 Dworkin *Life's Dominion* 35.

42 *Roe v Wade* 410 US 113 (1973).

43 See Theriot and Connelly 2017 *Ariz St LJ* 558-559.

44 See De Freitas 2011 *IJRF* 75-85.

protect innocent human life, even when it is accompanied by pain and suffering. What one is dealing with in these instances are contentious moral matters related to the beginning and ending of human life, which is a topic that is in and of itself of fundamental importance. In such matters, sensitivities need to be protected.

The conscientious objection that the medical practitioner holds becomes even more credible and sincere when taking into cognisance the said practitioner's intense belief that the administering of euthanasia constitutes murder, which is a violation of the Divine Commandment, "Thou shall not kill".[45] The protection of the conscience regarding an act or omission remains an important freedom that should be protected as it inexorably connects (as alluded to earlier) with the protection of human dignity. This has to do with what Steven Smith refers to as "being a full person" or what Martin Belsky considers the conscience, the free exercise whereof being the[46]

> ability of individuals … to be free from coercion so that they can act or not act in accordance with some 'core personal beliefs or principles'.

Mark Wicclair refers to Jeffrey Blustein's observation that when one acts against one's conscience,[47]

> … one violates one's own fundamental moral or religious convictions, personal standards that one sees as an important part of oneself and by which one is prepared to judge oneself.

Wicclair adds that an unprotected conscience may result in: (1) the harming of a person's concept of a good or meaningful life; (2) feelings of guilt, remorse, shame and self-respect; and (3) a decline in a person's moral character (which is especially undesirable for a medical practitioner).[48] From the above it is therefore evident that the protection of the right to freedom of religion and its inextricable relation to human dignity and the conscience is of fundamental importance. It should therefore be approached with the

---

45 For confirmation of this Biblical precept, see, for example, Pope John Paul II's *Evangelium Vitae* paras 41, 48, 53 and 77. Pope John Paul II refers to the following section of the *Donum Vitae,* namely: "Human life is sacred because from its beginning it involves the 'creative action of God', and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life … Precisely for this reason God will severely judge every violation of the commandment 'You shall not kill …" (see para 53). Also see Pope John Paul II's *Evangelium Vitae* para 55 (which includes the exception of taking a life when it is in self-defence).

46 Araujo 2007 *Miss LJ* 584.

47 Wicclair *Conscientious Objection in Health Care* 26.

48 Wicclair *Conscientious Objection in Health Care* 26.

necessary understanding regarding the protection of the medical practitioner's objection against participating in the administering of euthanasia.

4 The test for a reasonable and justifiable limitation

The relationship between the medical practitioner and the patient against the background of conscientious objection against the administering of euthanasia naturally leads to a conflict of rights, whether shared or different. Therefore, the test to determine whether there is a reasonable and justifiable limitation, in accordance with section 36(1) of the *Constitution of the Republic of South Africa*,[49] of the rights of the medical practitioner in the event that the medical practitioner would be pressured to take part in an instance of euthanasia, is not only relevant but a necessity. As will become clear, an unreasonable and unjustifiable infringement of the medical practitioner's rights indeed occurs when the practitioner is compelled by the law to administer euthanasia in opposition to his/her religious convictions. Bearing the above in mind, an identification of and consequent investigation of the relevant rights in addition to the right to freedom of religion (and consequently, of the conscience)[50] is required. To begin with, the right to life will be elaborated upon, as this right is, for obvious reasons, foundational regarding the debate on euthanasia. By focussing on the importance and scope of the right to life, the credibility of the medical practitioner's conscientious objection against participating in euthanasia is argued for, which in turn supports his/her right to human dignity, to freedom of religion and to privacy (which overlaps with personhood and autonomy), these being rights that will be discussed below and that will further the argument for the protection of the medical practitioner who objects against participating in euthanasia.

4.1 The relevant human rights

> An awareness of the importance and sanctity of human life is inherent in the mind of persons in general, an understanding

---

49 Which reads as follows: "(1) The rights in the Bill of Rights may be limited only in terms of the law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including – (*a*) the nature of the right; (*b*) the importance and purpose of the limitation; (*c*) the nature and extent of the limitation; (*d*) the relation between the limitation and its purpose; and (*e*) less restrictive means to achieve the purpose. (2) Except as provided in ss (1) or in any other provision of the Constitution, no law may limit any right entrenched in the Bill of Rights."

50 Which has been substantively dealt with earlier on.

> which is important when dealing with the termination[51] of innocent human life. Craig Paterson states that life is a grounding good, because it sustains all of our choices and actions, and in this regard it is of instrumental value. Life is also of intrinsic importance[52] and enjoys protection, as prescribed by the *Constitution of the Republic of South Africa,* which states, "Everyone has the right to life",[53] and by international human rights instruments.[54] Having said this, the attainment of consensus related to an understanding of "life" and its worth proves to be most difficult in the context of the debate on the legalisation of euthanasia. This is explained in the context of the right to privacy (which substantively overlaps with the right to personhood, autonomy and freedom of the person). In this regard, Robert George points out that there are those supporters of the legalisation of euthanasia who distinguish mere biological human life from the life of a person. This entails understanding that a person possesses developed capacities for:[55]
>
> > … characteristically human mental activity, such as conceptual thinking, deliberation, and choice. According to this understanding, it is 'personal life' that has intrinsic value and dignity whilst 'biological life' does not.
>
> Explained further, this approach views a living human body,[56]
>
> > … not as a person until it becomes associated with a mind and such a body ceases to be a person, not only by dying, but at any point at which it loses this association of mind and body.

This is in contrast with the view that bodily life *per se* denotes an intrinsic good and is therefore an end in itself. The human physical or biological entity (which includes the retarded and the comatose) is sufficient to qualify as human life, and should therefore enjoy protection. In other words, the body does not have a merely and exclusively *instrumentalist* attribute; rather the body constitutes primarily *an intrinsic good*. For example, the life of a new-

---

51 For this very reason, there are those who view euthanasia as the "killing" of innocent human life rather than as the "termination" of human life.

52 Paterson *Assisted Suicide and Euthanasia* 51. Paterson adds that "Due respect for the primary good of human life minimally demands that we always refrain from actions intent on killing an innocent person" (see 104).

53 *Constitution of the Republic of South Africa*, 1996 s 11.

54 For example, see art 6 of the *International Covenant on Civil and Political Rights* (1966) and art 4 of the *African Charter on Human and Peoples' Rights* (1981). Daniel Solove's adept study on the conceptualising of privacy, points to an understanding of the right to privacy as including the right of every individual to have "control and dominion over decisions regarding one's body", Solove 2002 *CLR* 1135.

55 George 2006 *Touchstone* 32.

56 George 2006 *Touchstone* 32.

born baby, although the baby is substantively under-developed regarding its intellectual and experiential ability, remains nevertheless a human life that should enjoy full protection:[57]

> No one doubts, for example, that a day-old-human infant or the very senile may lack the actual capacities of, for example, a day old foal … But surely this sort of comparison does not convince us that foals somehow have greater fundamental worth than human infants or the very senile. If anencephalic infants or the very senile were, say, intentionally killed and sold for food, we would surely find such a practice deeply undignified and repugnant … if the true worth of individual human beings, at the end of the day, were held to be ultimately and contingently dependent on having some ready prospect for individually exercising capacity X or capacities X … rather than their having 'radical dignity by virtue of their essential nature,' there should – apart from obvious health concerns or feelings of squeamishness or dealing with the reaction of relatives – be no deep moral problem with intentionally killing such profoundly damaged human beings in order to make use of their harvested dead flesh for the manufacture of consumer edibles.[58]

This confirms the importance of human life and the understanding that human biological life *per se* remains substantively important and sacred.[59] The right to human dignity also comes into play. References in the constitutions of democratic states and international human rights instruments to the need to respect the "dignity" or "inherent human dignity" of a human being can be viewed as confirming the intrinsic worth of a human being. Not only is the freedom of a person's will part of the idea behind respect for a person's dignity, but it plays a role in ensuring respect for a person's psychological integrity as well.[60] Accordingly, the first "element" in a proper definition of the right to human dignity would be respect for both physical and psychological integrity.[61] Oscar Schachter adds that respect for dignity would mean that the whims and wishes of one or few members of society cannot be used as a coercive tool against the free will of an individual; neither can governments impose and enforce beliefs that subject an individual or a group's views to conformity with their own, thereby asserting their authority over an individual's life that is personal and familial

57 Finnis *Human Rights and Common Good* 247-248.

58 Paterson *Assisted Suicide and Euthanasia* 138-139. Paterson also states, "Bodies are not 'prisons of the immortal soul' nor are they 'mere biological equipment.' Bodies are intrinsically and not merely extrinsically valuable to us because they are seamlessly integral to the very reality of who and what we are as persons. A body is not something 'sub-personal' to 'personal life' as if X (consciousness life) can be radically juxtaposed with Y (bodily life) such that X can be held intrinsically valuable to us but not Y. Both X and Y are fully integral to our personal beingness" (see 51).

59 Finnis 1993 *S Ill U LJ* 568-569.

60 Schachter 1983 *AJIL* 849.

61 Barroso 2012 *B C Int'l & Comp L Rev* 364.

to that person.[62] In addition to ensuring respect for a person's inherent worth, the recognition of an individual's personal responsibility should be accentuated. This refers to the capacity of a person to make individual choices that give expression to his/her distinct identity,[63] which in turn relates to the enjoyment of dignity. Addressing the relationship between human dignity and the importance of ensuring religious freedom, Langa CJ in *Pillay* adds that religious practices are[64]

> … protected because they are central to human identity and hence to human dignity which in turn is central to equality.

Pope John Paul II emphasised the inextricable connection between human dignity and the right to object conscientiously with specific reference to the administering of euthanasia in the following:[65]

> To refuse to take part in committing an injustice is not only a moral duty; it is also a basic human right. Were this not so, the human person would be forced to perform an action intrinsically incompatible with human dignity, and in this way human freedom itself, the authentic meaning and purpose of which are found in its orientation to the true and the good, would be radically compromised. What is at stake therefore is an essential right which, precisely as such, should be acknowledged and protected by civil law. In this sense, the opportunity to refuse to take part in the phases of consultation, preparation and execution of these acts against life should be guaranteed to physicians, health-care personnel, and directors of hospitals, clinics and convalescent facilities.

Compelling a person to abandon his/her religious convictions or to assist another to do something that is in his/her eyes abhorrent and which can be viewed as entirely irrational against the background of understanding human life to be substantively important and sacred constitutes a grave infringement on the inherent dignity of such a person. If a medical practitioner is forced to act in contradiction of his/her sincerely held convictions, this would amount to a non-recognition of his/her inherent worth in society, and consequently his/her beingness would be grossly violated.

The next relevant right to be investigated is the right to privacy, a popular, yet complex right[66] used in support of the justification of euthanasia.[67]

---

62 Schachter 1983 *AJIL* 850.

63 *MEC for Education: KwaZulu-Natal v Pillay* 2008 1 SA 474 (CC) para 63.

64 *MEC for Education: KwaZulu-Natal v Pillay* 2008 1 SA 474 (CC) para 62.

65 Pope John Paul II *Evangelium Vitae* para 74.

66 Solove points to the fact that scholars and jurists have lamented the great difficulty in attaining a satisfying conception of privacy and are of the view that the right to privacy is difficult to define, Solove 2002 *CLR* 1088-1090.

67 Klein 1994 *Leg Ref Serv Q* 138; Wolhandler 1984 *Cornell L Rev* 375; Novak *Sanctity of Human Life* 147.

However, as is argued below, the medical practitioner himself/herself is also entitled to protection of this right. In South Africa the right to privacy is guaranteed in the *Constitution*.[68] An understanding of the right to privacy in Western democracies has been extended from only an "informational" sense, namely preventing the dissemination of one's personal information, to including substantive concepts relevant to the everyday life of the person holding the right,[69] such as marriage, contraception, education and child rearing. It is understood that the term "personhood" includes ideas referring to a person's individuality, privacy and autonomy,[70] or to who the person is according to his/her own mind and spirit. It further grants one the right to be left to one's own devices. It refers to a rebuttable presumption that a citizen ought to be free to live his/her life in the manner of his/her choosing without the government interfering or telling him/her how it should be lived.[71]This support of absolute autonomy and freedom of control over one's mind involves, in a medical context, the right to choose whether, in line with one's own values and beliefs, one would submit to a particular recommended course of treatment.[72] Bearing the above in mind, the critical question needs to be asked whether compelling a medical practitioner to grievously transgress his/her own religious convictions, and to his/her mind, commit a heinous act, does not amount to a serious invasion of his/her right to privacy and by implication his/her right to autonomy, personhood and self-determination? This should surely be answered in the affirmative, as is confirmed by Daniel Garros's observation that:[73]

> As the principle of respect for a patient autonomy is MAID's[74] pillar, it follows that the HCP's autonomy in deciding to refuse to participate in MAID should be equally respected.

Having investigated and elaborated upon the various rights related to a medical practitioner who objects to the administering of euthanasia, the

---

68 Section 14 of the *Constitution* holds that everyone has the right to privacy and it goes further by stating that this right "*includes* the right not to have their home or person searched, have their possessions unlawfully seized, their property searched or have the privacy of their communications infringed" (emphasis added).

69 Rubenfeld 1989 *Harv L Rev* 740.

70 Craven 1976 *Duke LJ* 702. Solove also connects privacy to personhood and adds that personhood relates in turn amongst others to individuality and autonomy, which in turn relate to the right of the individual to make choices regarding his/her body, Solove 2002 *CLR* 1116-1117. Also see 1117 for Solove's criticism related to personhood as an overly broad term.

71 Craven 1976 *Duke LJ* 706. Also see McClain 1995 *Yale JL & Human* 195.

72 Giesen "Dilemmas at Life's End" 201.

73 Garros 2017 *Health Ethics Today* 7. This statement by Garros, a medical practitioner, is in response to the recent legalisation of euthanasia (or medical assistance in dying) in Canada.

74 MAID stands for Medical Assistance in Dying.

application of the general limitations clause follows, to confirm that an unreasonable and unjustifiable infringement of the medical practitioner's rights indeed occurs when the practitioner is compelled to participate in the administering of euthanasia.

4.2 The general limitations clause test

The first of the listed criteria that the general limitations clause looks at is the nature of the relevant human rights and whether these rights have been violated. The nature of the relevant rights of the medical practitioner, namely the rights to freedom of religion, human dignity and privacy (which overlaps with personal autonomy) was elaborated on earlier. It was explained that to compel a medical practitioner to participate in the administering of euthanasia violates the said rights of the practitioner. The violation of the convictions of the medical practitioner whose religious and moral frame of reference supports the protection of innocent life may lead to extreme psychological trauma.[75] Many religions also observe the foundational inviolability and sacredness of innocent human life.[76]

Regarding the importance and purpose of the limitation of the medical practitioner's rights, which comprises the second of the listed criteria of the limitations clause, is the termination of pain and suffering (which may not only be viewed from the perspective of physical pain and suffering but also from the perspective of psychological trauma). Inextricably related to this is the view that distinguishes between human experience and choice (that which pertains to the mind) on the one hand and the human biological make-up (the body) on the other. It was argued earlier that the qualification of the termination of human life, in accordance with the view that experiential life may no more be enjoyed, flouts the sanctity of human life, which is also comprised of a biological dimension. In this regard, the importance of the purpose of the limitation (as resulting from euthanasia) as argued by those who distinguish between life as experience (mind) and biological human life

75 The effects of compulsion to contravene sincere beliefs are elaborated upon below.

76 Regarding for example Christians and Jews, the first book of the Bible, namely, Genesis, is of relevance. According to Genesis 1:27: "… God created man in his own image, in the image of God he created him; male and female he created them." ESV (English Standard Version). Human life is therefore to be lived in accordance with the representation of its origin. Secondly, Genesis 2:7 indicates the difference between human life and any other: "Then the Lord God… breathed into his nostrils the breath of life, and the man became a living creature". Humans are accordingly believed to be creatures with divine attributes derived directly from God and therefore it is staunchly believed that it is not within the authority of a person to take the life of an innocent human being intentionally. In addition, according to the Gospel of Matthew, "You shall love your neighbour as yourself", Matthew 22:37-39.

(body) lends itself to critique, which in turn strengthens the credibility of the medical practitioner who refuses to participate in the administering of euthanasia. This is further substantiated by the arguments presented earlier on regarding the intrinsic worth of even exclusive biological life. In addition, an argument against the administering of euthanasia is that there are improved levels of palliative care and medication to limit the physical and mental suffering that a patient may experience. This point of view also assists in the weakening of the importance of the purpose of the limitation. According to Broude:[77]

> Changing attitudes towards the effective use of narcotic analgesics, the development of new routes and methods of administration, and a clinical approach based on scientific principles and humane care offer the promise of improved management of pain in terminally ill patients.

John Finnis refers to Peter Admiraal, a leading Dutch exponent (and practitioner) of euthanasia, who stated in the mid-1980s that

> … pain is never a legitimate reason for euthanasia because methods exist to relieve it.[78]

The very reason for palliative care is to assist those terminally ill patients in coping with their pain and suffering. In this regard, Craig Paterson comments:[79]

> Quality-of-life concerns should always be focused on the ways and means in which humanitarian resources can be deployed to improve the health of patients and should not be conflated with attempts to assess the overall 'benefits of living' versus the 'benefits of death' as if the two can really be rationally weighed and compared to one another. Let me be quite clear that I am not seeking to trivialize in any way the burdens on life imposed by illness … Yet, notwithstanding the heavy toll those burdens inflict on patients, the only reasonable way to respond to those burdens is to do all we can to cure or diminish the pain and suffering of patients *as best we can*. We constantly need to remind ourselves that a life that is severely diminished in 'quality' is still capable of realizing and participating in a wide array of primary and secondary human goods – friendship, family, beauty, truth, etc.

Paterson rightly points out that rationality, consciousness, self-awareness, moral agency, communication, emotionality and the capacity to feel pain, as the selected criteria in deciding on death, result in a plethora of critical questions such as: What level of self-awareness is required? What does it really mean to be self-aware? Which of the above criteria should be

77 Broude 1987 *SAMJ* 543.
78 Finnis 1998 *Loy LA L Rev* 1141; Finnis *Human Rights and Common Good* 266.
79 Paterson *Assisted Suicide and Euthanasia* 107.

prioritised or do they all carry the same weight?[80] In the words of Craig Paterson:[81]

> Threshold definitions of persons seem so contrived precisely because they do resort to such arbitrary and vague stipulations when seeking to 'pick' and 'select' features and levels for determining the category of persons from the category of non-persons.

This complexity consequently weakens the importance of the limitation as well. In addition, if the emphasis and importance were to be solely placed on the autonomy of the patient wishing to have his/her life terminated, then what about the medical practitioner's right to personal autonomy, self-determination and privacy, which in turn includes reason, emotions, moral agency, self-awareness and sentience? Added to this is the fact that euthanasia concerns the intentional termination of innocent human life and this alone elevates the argument in support of the non-termination of human life in the context of euthanasia to even higher levels of credibility and rationality.

The third criterion of the general limitations clause pertains to an analysis regarding the nature and extent of the limitation. In this regard, it is important to understand the medical practitioner's aversion to euthanasia from his/her contextual perspective. The belief in the absolute inviolability of innocent life and the respect it attracts is recognised in many religions. Ordinarily, intentionally killing innocent human life is outright prohibited.[82] The severe effects such compulsion would exert on the practitioner's human dignity cannot be overly emphasised; as such, a person may believe himself/herself to be a murderer, subject to punishment. The aversion by a religious medical practitioner is not influenced solely by his/her obedience to religious texts; a deeper understanding of the religious psyche is necessary, especially in matters such as euthanasia that deal with the intentional termination of an innocent human life. Many religious persons stand in a perceived position of ultimate accountability towards what is believed to be an almighty and omnipotent God (or gods).[83] It is therefore

---

80 Paterson *Assisted Suicide and Euthanasia* 134.

81 Paterson *Assisted Suicide and Euthanasia* 35.

82 In Judaism and Christianity, the Ten Commandments specifically address and prohibit murder. See Exodus 20. The Quran in chapter 5:32 determines that the killing of one person is akin to the killing of the whole of humankind. Hindus, Jains and Buddhists abhor violence. For example, Hindu and Jain followers of Swaminarayan have the explicit commandment "Thou shalt not kill", which Swaminarayan considered true to original ancient Vedic teaching. Williams *Introduction to Swaminarayan Hinduism* 159.

83 Polanyi *Personal Knowledge* 302.

challenging to believe that compelling a medical practitioner to participate in the administering of euthanasia does not result in substantive psychological distress. Daniel Garros points us to credible studies that have confirmed that it is naturally difficult for human beings to terminate the lives of others and that even those in the military require "massive techniques of decentralisation to be able to live with the consequences of killing during war".[84] Although some might argue that the war context differs from the context of healthcare, this serves as an indication of the serious consequences related to the taking of human life *per se*.

Regarding the relationship between the limitation and the purpose, which constitutes the fourth listed criterion of the general limitations clause, cognisance must be taken of the view expressed in *S v Steyn*,[85] namely that a rational relationship ought to be found between a limitation and its purpose.[86] The question therefore to be asked is whether the limitation would ensure that its purpose is achieved.[87] The purpose related to the case at hand is that the patient who is terminally ill and who experiences pain should be allowed to die with dignity at the hands of a medical practitioner, either by means of active or passive forms of euthanasia. In this regard, the administering of euthanasia is understood to be of such vital constitutional importance that it would warrant compelling a medical practitioner to deny his/her own sincerely held convictions by limiting his/her free religious exercise substantively and invasively. The patient relies on the protection of his/her right to personal autonomy (which in turn implies the patient's right to protection of human dignity and privacy, as well as freedom and security of the person). The extent of this has been indicated clearly: personal inviolability involves not only being physically in control of one's body, but psychologically as well. The patient's will to live has subjectively diminished to the point where death becomes the preferred option, which is often because of the constant pain and suffering experienced. This pain and suffering supplements the purpose of the limitation, namely that maintaining the suffering of a person constitutes cruel treatment and the effects of the suffering often cause embarrassment to the patient and infringe upon his/her dignity.[88] Here cognisance needs to be taken of the earlier argument

84 Garros 2017 *Health Ethics Today* 9.
85 *S v Steyn* 2001 1 SA 1146 (CC).
86 *S v Steyn* 2001 1 SA 1146 (CC) paras 30-31.
87 Rautenbach 2014 *PELJ* 2256.
88 *Stransham-Ford v Minister of Justice and Correctional Services* 2015 4 SA 50 (GP) paras 9.3-9.5: "As time progresses the Applicant's condition will become progressively worse and will later on require an even stronger doses of opioid drugs such as morphine and to possibly be hospitalized. He is becoming weaker by the day and needs constant assistance in normal daily activities such as getting up from

regarding the modern-day successes of palliative treatment as well as the questionable nature of the view that the body should be separated from the mind. Added to this, the critical questions presented by Craig Paterson (referred to earlier) regarding rationality, consciousness, self-awareness, moral agency, communication, emotionality and the capacity to feel pain as the selected criteria in deciding on death, should also be noted. These most certainly lessen the rational connection between the limitation and the purpose. It also needs to be noted that, in the event of the legalisation of euthanasia, the request of the patient would be limited only as far as his/her request is denied by a medical practitioner whose personal religious beliefs conflict with the patient's request. This means that the patient remains free to request another medical practitioner to assist him/her, thereby ensuring the protection of the patient's rights to privacy, freedom and security of the person as well as human dignity.

The final determination according to the listed grounds in the general limitations clause is the determination whether there are other, less restrictive measures available that would achieve the same results. Therefore, should a party suggest a limitation, it should be proven that alternative measures, if any, had been considered, but that no option could be found that would achieve the desired result, leaving only the limiting option. In determining a less restrictive means, the court has made it clear that the standard to be attained should be realistic and reasonable.[89] Less restrictive means may include placing more focus and effort on the application of palliative treatment. Then there is the proposal pertaining to a "roll" that can be compiled, along the lines of the "roll of non-objecting physicians". Such a roll would allow a patient to approach any medical practitioner on the roll directly, who would accordingly be authorised to acquiesce to the patient's request.[90] Having said this (and for reasons argued throughout this article), it should remain the choice of the medical practitioner whether she would want to participate in the administering of

bed, bathing, brushing his teeth and eating. As the Applicant's disease progresses and until his last breath, he will become confused and afraid. His last breath might even be with the aid of a machine. Applicant says that he is not afraid of dying, he is afraid of dying while suffering".

89 *S v Mamabolo* 2001 3 SA 409 (CC) para 49.

90 Such a roll should contain all the relevant details of the practitioner, including details regarding the area in which s/he performs his/her duties, and contact details to facilitate quick and efficient assistance. Also see Benson 2008 https://www.cardus.ca/organization/news/625/physicians-patients-human-rights-and-referrals-a-principled-approach-to-respecting-the-rights-of-physicians-and-patients-in-ontario.

euthanasia, even in the absence of other practitioners who may be willing to assist in administering euthanasia.

Those in support of euthanasia would argue that the limitation seeks to attain an admirable goal, but is the limitation reasonable and justifiable in an open and democratic South Africa based on human dignity, freedom and equality? It is clear from the above that compelling a person to act against his/her beliefs, knowing the toll which contravening his/her religious prescripts would levy, comprises a degrading, cruel and inhumane action. In addition, the State can indeed effect a less invasive approach, which would amount to the inclusion of a "conscientious objection clause" in possible future euthanasia legislation. Such a clause would cater effectively to the guaranteed rights of the medical practitioner, whilst providing the patient with the possibility of requesting another medical practitioner to assist in terminating his/her life.

Here it is also apt to refer to equality jurisprudence (and by implication the possibility of unfair discriminatory practices). Section 9 of the *Constitution of the Republic of South Africa* is clear on religion's constituting one of the listed grounds regarding unfair discrimination. In this regard, it is argued that instructing or pressuring a medical practitioner into participating in the administering of euthanasia even though it is against such a practitioner's religious convictions may result in unfair discrimination. Elaborating upon this, section 1 of the *Promotion of Equality and Prevention of Unfair Discrimination Act*[91] defines "discrimination" as:

> … any act or omission, including a policy, law, rule, practice, condition or situation which directly or indirectly – (a) imposes burdens, obligations or disadvantage on; or (b) withholds benefits, opportunities or advantages from, any person on one or more of the prohibited grounds.

In addition, the *Equality Act* lists criteria to assist in the determination of whether certain actions may constitute unfair discriminatory practices.[92]

---

91 *Promotion of Equality and Prevention of Unfair Discrimination Act* 4 of 2000 (PEPUDA), commonly referred to as the *Equality Act*.

92 Section 14(2)-(3) of the *Equality Act* reads as follows: "(2) In determining whether the respondent has proved that the discrimination is fair, the following must be taken into account: (a) The context; (b) the factors referred to in ss (3); (c) whether the discrimination reasonably and justifiably differentiates between persons according to objectively determinable criteria, intrinsic to the activity concerned. (3) The factors referred to in ss (2) (b) include the following: (a) Whether the discrimination impairs or is likely to impair human dignity; (b) the impact or likely impact of the discrimination on the complainant; (c) the position of the complainant in society and whether he or she suffers from patterns of disadvantage or belongs to a group that suffers from such patterns of disadvantage; (d) the nature and extent of the discrimination; (e) whether the discrimination is systemic in nature; (f) whether the discrimination has a

Applying these criteria to the matter at hand, it becomes clear that there will be unfair discrimination where a medical practitioner is compelled to participate in the administering of euthanasia.

The fact that such a medical practitioner finds himself/herself in the workplace, results in the *Employment Equity Act* (EEA)[93] also having to come into play, and in this regard the emphasis is placed on whether such a medical practitioner should be "'reasonably accommodated"'. Pretorius *et al* state that:[94]

> The duty of reasonable accommodation comprises of positive measures that ought to be taken to meet … the different needs of those who, by reason of a protected characteristic such as … *religious affiliation* cannot be adequately served by arrangements that are suitable for people who do not share such a characteristic.

According to Pretorius *et al*:[95]

> … read with the prohibition on unfair discrimination contained in sections 6(1) and (2),[96] as well as the constitutional guarantee of religious freedom, reasonable accommodation of religious practices and beliefs have to be adhered to by employers. Failure to reasonably accommodate may constitute direct or indirect discrimination based on religious belief.

Pretorius *et al* refer to the requirements for a successful claim regarding workplace-based religious discrimination as set out by the Labour Appeal Court in *SA Clothing and Textile Workers Union v Berg River Textiles – A*

---

legitimate purpose; (g) whether and to what extent the discrimination achieves its purpose; (h) whether there are less restrictive and less disadvantageous means to achieve the purpose; (i) whether and to what extent the respondent has taken such steps as being reasonable in the circumstances to – (i) address the disadvantage which arises from or is related to one or more of the prohibited grounds; or (ii) accommodate diversity". The relevance of these criteria (emanating from the *Equality Act*) for the workplace (which falls under the direct authority of the *Employment Equity Act* 55 of 1998 (see below) was confirmed in *Du Preez v Minister of Justice and Constitutional Development* 2006 3 All SA 271 (SE) para 25.

93 One of the main objectives of this Act is to forbid unfair discrimination (based amongst other concerns on the listed grounds, which include religion) in the workplace.

94 Pretorius, Klinck and Ngwena *Employment Equity Law* 2 (emphasis added).

95 Pretorius, Klinck and Ngwena *Employment Equity Law* 54.

96 The *Employment Equity Act* 55 of 1998. S 6(1) reads as follows: "No person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including … religion … conscience … belief … culture … "

Division of Seardel Group Trading (Pty) Ltd,[97] these being, amongst others that:[98]

> … it is incumbent on the [employees] to show that the employer by means of the workplace rule or policy interfered with their participation in or practice of their religion and the principle involved must be a central tenet of that religion.

Applying the above to the scenario where a medical practitioner who refuses to participate in the administering of euthanasia due to his/her religious convictions is instructed or pressurised into participating in the procedure, surely this would constitute a successful claim regarding unfair discrimination based on religion (and by implication, conscience)?[99] Added to this, a hospital that has employed such a medical practitioner is necessitated to accommodate the practitioner reasonably. It is therefore clear that to instruct (or pressurise in any manner whatsoever) a medical practitioner to administer euthanasia where such an action is opposed to the practitioner's religious convictions (and consequently his/her conscience) would constitute unfair discrimination.[100] One also needs to bear in mind that whatever the finding may be regarding the determination of unfair discrimination in accordance with the EEA and PEPUDA, an argument that this is a reasonable and justifiable limitation (in accordance with section 36 of the Constitution) of the medical practitioner's right mainly

97 *SA Clothing and Textile Workers Union v Berg River Textiles – A Division of Seardel Group Trading (Pty) Ltd* 2012 33 ILJ 972 (LC).

98 Pretorius, Klinck and Ngwena *Employment Equity Law* 55.

99 This is especially supported by the earlier argument pertaining to the importance of religion and the convictions of the medical practitioner who objects against the administering of euthanasia due to his/her religious belief and the centrality of such a belief to his/her religion.

100 Earlier discussions add to this argument where the importance of the relevant rights (especially those pertaining to the right to freedom of religion and human dignity) were discussed in detail. Here cognisance also needs to be taken of the relevance of the *Labour Relations Act* 66 of 1995 (LRA) against the background of possibilities of "unfair dismissals". In other words, a doctor who has been dismissed by the hospital management for refusing to participate in any act of euthanasia may argue that s/he has been unfairly dismissed. In this regard, Du Plessis and Fouché state that "In terms of s 187 of the LRA some dismissals are automatically unfair. In the main a dismissal is automatically unfair if an employer discriminates against an employee or if an employee is dismissed because he exercised his rights in terms of the Act". Du Plessis and Fouché *Practical Guide to Labour Law* 320-321. More specifically, and amongst others, a dismissal because of the employer's unfair discrimination qualifies such a dismissal as an automatically unfair dismiss. It was argued above that instructing or pressurising (in any manner whatsoever) a medical practitioner to administer euthanasia against his/her religious convictions constitutes unfair discrimination and therefore to dismiss a medical practitioner due to such a practitioner's not wanting to violate his/her own religious beliefs and convictions through the administration of euthanasia automatically constitutes an unfair dismissal.

to human dignity and freedom of religion would certainly not succeed (as argued earlier).

5 Conclusion

This article argues for the protection of the medical practitioner who would conscientiously object to the administering of euthanasia, if euthanasia were to be legalised in South Africa along the lines of the position in Belgium, Canada and the Netherlands, for example, Such an objection would foundational to the objector's religious convictions and human dignity, as well as his/her personal autonomy, and would be inextricably connected with his/her apperception of the importance and sanctity of human life. Emanating from this understanding is the view that bodily life is an intrinsic good and is therefore an end in itself, not a mere instrument towards the attainment of something seemingly more important. From the point of view of the patient who chooses to die, such a request is viewed by the pro-euthanasia camp as being in accordance with the right to privacy (and personal autonomy) and ultimately the right to human dignity, and that consequently the parameters of the right to life are viewed by the pro-euthanasia camp as qualifying for the termination of life. Therefore the expectation is that as service providers the medical staff at a hospital (whether public or private) should grant such a request. Under normal circumstances it is generally expected of a service provider to provide its services without discriminating on any grounds. However, even as the patient claims protection of his/her rights to privacy and human dignity, so too should the medical practitioner claim protection of his/her rights to freedom of religion and conscience, privacy, and human dignity, rights that are better understood in the context of conscientious objection against participating in the administration of euthanasia, when taking into cognisance the importance of innocent human life, even when viewed exclusively from a biological context. In this regard, arguments have been presented confirming the importance of the protection of the rights of the medical practitioner.

Bearing the above in mind, pro-euthanasia legislation will have to include a conscientious objection clause, which protects the interests of the medical practitioner who may want to be excluded from the administering of the forms of euthanasia described earlier on. Such a clause should provide the medical practitioner, whether such practitioner is a medical doctor, a nurse, a pharmacist or any other person involved in the process of administering of euthanasia (whether directly or indirectly), upon request, the option to

refuse participation, if such refusal is based on sincerely[101] held religious (or other) beliefs. The general limitation clause has been thoroughly applied (above) to assist in the determination of whether the rights of the medical practitioner may be reasonably and justifiably limited. The finding emanating from this is that it would constitute an unjustifiable and unreasonable limitation to have a medical practitioner participate against his/her will in the administering of euthanasia. Therefore, should euthanasia (and PAS) be legalised in South Africa, as in Canada, Belgium and the Netherlands, for example, a clause ought to be contained in the corresponding legislation that would cater to the needs of medical practitioners who may be troubled by their consciences. Such a clause should not only afford the practitioners the opportunity to refuse to act in accordance with the patient's request, but also accommodate the possibility that a practitioner, unlike practitioners in other jurisdictions, may refuse to direct the patient to another medical practitioner. As to a formulation pertaining to the reading of such a conscientious objection clause, the following is proposed:[102]

> No person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any diagnosis, treatment, omission of treatment or other action authorised by this Act[103] to which he has a conscientious objection. If an attending physician whose patient makes a request to be assisted to die in accordance with this Act has a conscientious objection as referred to earlier, he shall not be responsible for ensuring that the patient is referred to an attending physician who does not have such a conscientious objection.

A number of states around the world have legalised euthanasia practices within the healthcare system. There are also developments in other states tending towards the enactment of euthanasia legalisation. It is most certainly not a distant possibility that euthanasia legislation may become a reality in South Africa. These developments and possibilities call for the accommodation of the right of a medical practitioner to object conscientiously to the administering of euthanasia.

---

101 Regarding sincerity as a requirement, the South African Constitutional Court is of the view that: "A religious belief is personal, and need not be rational, nor need it be shared by others. A court must simply be persuaded that it is a profound and sincerely held belief". *MEC for Education: KwaZulu-Natal v Pillay* 2008 1 SA 474 (CC) para 146. Also see *Minister of Home Affairs v Fourie* 2006 1 SA 524 (CC) para 159.

102 Having taken as a guide Britain's *Assisted Dying for the Terminally Ill Bill* [HL Bill 17] and the *Assisted Dying Bill* [HL Bill 24], which was drafted after *the Assisted Dying for the Terminally Ill Bill*.

103 By "Act" is intended euthanasia legislation of the type reflected in Canada, Belgium and the Netherlands.

Bibliography

Literature

Ahdar and Leigh *Religious Freedom*
Ahdar R and Leigh I *Religious Freedom in the Liberal State* (Oxford University Press Oxford 2013)

Araujo 2007 *Miss LJ*
Araujo RJ "Conscience, Totalitarianism, and the Positivist Mind" 2007 *Miss LJ* 77 571-621

Barroso 2012 *B C Int'l & Comp L Rev*
Barroso LR "Here, There and Everywhere: Human Dignity in Contemporary Law and in the Transnational Discourse" 2012 *B C Int'l & Comp L Rev* 331-393

Beckwith and Geisler *Matters of Life and Death*
Beckwith FJ and Geisler N *Matters of Life and Death. Calm Answers to Tough Questions about Abortion and Euthanasia* (Baker Book House Grand Rapids, Mich 1991)

Beresford 2005 *Human Rights Research*
Beresford S "Euthanasia, the Right to Die and the Bill of Rights Act" 2005 *Human Rights Research* (Online) 1-24

Broude 1987 *SAMJ*
Broude AM "Pain Control in Terminal Illness" 1987 *SAMJ* 540-543

Chao, Chan and Chan 2002 *Family Practice*
Chao DVK, Chan NY and Chan WY "Euthanasia Revisited" 2002 *Family Practice* 128-134

Craven 1976 *Duke LJ*
Craven JB "Personhood: The Right to be Let Alone" 1976 *Duke LJ* 699-720

De Freitas 2011 *IJRF*
De Freitas S "Freedom of Conscience, Medical Practitioners and Abortion in South Africa" 2011 *IJRF* 75-85

Du Plessis and Fouché *Practical Guide to Labour Law*
Du Plessis JV and Fouché MA *A Practical Guide to Labour Law* 8th ed (LexisNexis Durban 2015)

Dworkin *Life's Dominion*
Dworkin RM *Life's Dominion: An Argument about Abortion and Euthanasia* (HarperCollins London 1993)

Egan 2008 *SAJBL*
Egan A "Should the State Support the 'Right to Die'?" 2008 *SAJBL* 47-52

Finnis 1993 *S Ill U LJ*
Finnis JM "The 'Value of Human Life' and 'the Right to Death': Some Reflections on *Cruzan* and Ronald Dworkin" 1993 *S Ill U LJ* 17 559-571

Finnis 1998 *Loy LA L Rev*
Finnis JM "Euthanasia, Morality, and Law" 1998 *Loy LA L Rev* 1123-1145

Finnis *Human Rights and Common Good*
Finnis JM *Human Rights and Common Good: Collected Essays Vol 3* (Oxford University Press Oxford 2011)

Finnis *Natural Law and Natural Rights*
Finnis JM *Natural Law and Natural Rights* 2nd ed (Oxford University Press Oxford 2011)

Garrard and Wilkinson 2005 *J Med Ethics*
Garrard E and Wilkinson S "Passive Euthanasia" 2005 *J Med Ethics* 64-68

Garros 2017 *Health Ethics Today*
Garros D "MAID is Legal in Canada: … I was not Trained to do this!" 2017 *Health Ethics Today* 6-13

George *Clash of Orthodoxies*
George RP *The Clash of Orthodoxies. Law, Religion, and Morality in Crisis* (ISI Books Wilmington 2001)

George 2006 *Touchstone*
George RP "Terminal Logic" March 2006 *Touchstone* 32-35

George *Conscience and its Enemies*
George RP *Conscience and its Enemies. Confronting the Dogmas of Liberal Secularism* (ISI Books Wilmington 2013)

Giesen "Dilemmas at Life's End"
Giesen D "Dilemmas at Life's End: A Comparative Legal Perspective " in Keown J (ed) *Euthanasia Examined: Ethical, Clinical and Legal Perspectives* (Cambridge University Press Cambridge 1995) 200-224

Keown *Euthanasia, Ethics and Public Policy*
Keown J *Euthanasia, Ethics and Public Policy: An Argument against Legalisation* (Cambridge University Press Cambridge 2004)

Klein 1994 *Leg Ref Serv Q*
Klein SS "The Right to Die as an Issue of Privacy: A Selective Bibliography" 1994 *Leg Ref Serv Q* 137-143

Mackinnon and Fiala *Ethics*
Mackinnon B and Fiala A *Ethics: Theory and Contemporary Issues* 9th ed (Cengage Learning Boston 2015)

Malherbe and Venter 2011 *TSAR*
Malherbe R and Venter R "Die Reg op Lewe, die Waarde van Menslike Lewe en die Eutanasie-Vraagstuk" 2011 *TSAR* 466-495

McClain 1995 *Yale JL & Human*
McClain L "Inviolability and Privacy: The Castle, the Sanctuary, and the Body" 1995 *Yale JL & Human* 195-241

McQuoid-Mason 2015 *SAJBL*
McQuoid-Mason DJ "*Stransham-Ford v Minister of Justice and Correctional Services and Others*: Can Active Voluntary Euthanasia and Doctor-assisted Suicide be Legally Justified and are they Consistent with the Biomedical Ethical Principles? Some Suggested Guidelines for Doctors to Consider" 2015 *SAJBL* 34-40

Novak *Sanctity of Human Life*
Novak D *The Sanctity of Human Life* (Georgetown University Press Washington DC 2007)

Paterson *Assisted Suicide and Euthanasia*
Paterson C *Assisted Suicide and Euthanasia. A Natural Law Ethics Approach* (Aldershot Ashgate 2008)

Polanyi *Personal Knowledge*
Polanyi M *Personal Knowledge: Towards a Post-Critical Philosophy* (Routledge London 1958)

Pretorius, Klinck and Ngwena *Employment Equity Law*
Pretorius Jl, Klinck ME and Ngwena CG *Employment Equity Law* (LexisNexis Durban 2012)

Rautenbach 2014 *PELJ*
Rautenbach IM "Proportionality and the Limitation Clauses of the South African Bill of Rights" 2014 *PELJ* 2229-2267

Rubenfeld 1989 *Harv L Rev*
Rubenfeld J "The Right of Privacy" 1989 *Harv L Rev* 737-807

Russel *Freedom to Die*
Russel OR *Freedom to Die: Moral and Legal Aspects of Euthanasia* (Dell New York 1976)

Schachter 1983 *AJIL*
Schachter O "Editorial Comment" 1983 *AJIL* 848-854

Slabbert and Van der Westhuizen 2007 *SAPL*
Slabbert M and Van der Westhuizen C "Death with Dignity in lieu of Euthanasia" 2007 *SAPL* 366-384

Solove 2002 *CLR*
Solove DJ "Conceptualizing Privacy" 2002 *CLR* 1087-1155

Theriot and Connelly 2017 *Ariz St LJ*
Theriot KH and Connelly K "Free to Do no Harm: Conscience Protections for Healthcare Professionals" 2017 *Ariz St LJ* 549-605

Wicclair *Conscientious Objection in Health Care*
Wicclair MR *Conscientious Objection in Health Care: An Ethical Analysis* (Cambridge University Press New York 2011)

Williams *Introduction to Swaminarayan Hinduism*
Williams RB *An Introduction to Swaminarayan Hinduism* (Cambridge University Press Cambridge 2001)

Wolhandler 1984 *Cornell L Rev*
Wolhandler SJ "Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy" 1984 *Cornell L Rev* 363-383

Case law

Christian Education South Africa v Minister of Education 2000 4 SA 757 (CC)

Du Preez v Minister of Justice and Constitutional Development 2006 3 All SA 271 (SE)

MEC for Education: KwaZulu-Natal v Pillay 2008 1 SA 474 (CC)

Minister of Home Affairs v Fourie 2006 1 SA 524 (CC)

Minister of Justice and Correctional Services v Estate Late James Stransham-Ford 2017 3 SA 152 (SCA)

Prince v President, Cape Law Society 2002 2 SA 794 (CC)

R v Big M Drug Mart Ltd 1985 1 SCR 295

Roe v Wade 410 US 113 (1973)

S v Lawrence 1997 4 SA 1176 (CC)

S v Mamabolo 2001 3 SA 409 (CC)

S v Steyn 2001 1 SA 1146 (CC)

SA Clothing and Textile Workers Union v Berg River Textiles – A Division of Seardel Group Trading (Pty) Ltd 2012 33 ILJ 972 (LC)

Stransham-Ford v Minister of Justice and Correctional Services 2015 4 SA 50 (GP)

Legislation

Assisted Dying Bill [HL Bill 24]

Assisted Dying for the Terminally Ill Bill [HL Bill 17]

Constitution of the Republic of South Africa, 1996

Employment Equity Act 55 of 1998

Labour Relations Act 66 of 1995

Mississippi Code Annexure § 41-107-3 (2016)

Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000

South African Law Commission Act 19 of 1973 (now the *South African Law Reform Commission Act* 19 of 1973, as amended by the *Judicial Matters Amendment Act* 55 of 2002)

International instruments

African Charter on Human and Peoples' Rights (1981)

International Covenant on Civil and Political Rights (1966)

UN Declaration on the Elimination of all Forms of Intolerance and of Discrimination Based on Religion or Belief (1981)

Internet sources

Benson 2008 https://www.cardus.ca/organization/news/625/physicians-patients-human-rights-and-referrals-a-principled-approach-to-respecting-the-rights-of-physicians-and-patients-in-ontario

Benson IT 2008 *Physicians, Patients, Human Rights, and Referrals: A Principled Approach to Respecting the Rights of Physicians and Patients in Ontario* https://www.cardus.ca/organization/news/625/physicians-patients-human-rights-and-referrals-a-principled-approach-to-respecting-the-rights-of-physicians-and-patients-in-ontario/ accessed 15 October 2017

Haigh and Bowal 2012 http://digitalcommons.osgoode.yorku.ca/clpe/316

Haigh R and Bowal P 2012 *Whistleblowing and Freedom of Conscience: Towards a New Legal Analysis* http://digitalcommons.osgoode.yorku.ca/clpe/316 accessed 6 August 2019

Moss 2013 http://www.dignityindying.org.uk/blog/assisted-dying-not-assisted-suicide/

Moss Z 2013 *Assisted Dying not Assisted Suicide* http://www.dignityindying.org.uk/blog/assisted-dying-not-assisted-suicide/ accessed 13 September 2016

Pope John Paul II 1995 http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html

Pope John Paul II 1995 *Evangelium Vitae (To the Bishops, Priests and Deacons, Men and Women, Religious Lay Faithful and all People of Good Will on the Value an Inviolability of Human Life)* http://w2.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html accessed 6 August 2019

List of Abbreviations

AJIL	American Journal of International Law
Ariz St LJ	Arizona State Law Journal
B C Int'l & Comp L Rev	Boston College International and Comparative Law Review
CLR	California Law Review
Cornell L Rev	Cornell Law Review
Duke LJ	Duke Law Journal
EEA	Employment Equity Act 55 of 1998
Harv L Rev	Harvard Law Review
Int J Family Med	International Journal of Family Medicine
IJRF	International Journal for Religious Freedom
J Med Ethics	Journal of Medical Ethics
Leg Ref Serv Q	Legal Reference Services Quarterly
Loy LA L Rev	Loyola of Los Angeles Law Review
LRA	Labour Relations Act 66 of 1995
MAID	Medical Assistance in Dying
Miss LJ	Mississippi Law Journal
PAS	Physician-Assisted Suicide
PELJ	Potchefstroom Electronic Law Journal
PEPUDA	Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000
S Ill U LJ	Southern Illinois University Law Journal
SAJBL	South African Journal of Bioethics and Law
SAMJ	South African Medical Journal
SAPL	Southern African Public Law
SCA	Supreme Court of Appeal
TSAR	Tydskrif vir die Suid-Afrikaanse Reg
Yale JL & Human	Yale Journal of Law and the Humanities